Name:_____ **SS#**_____
(LAST) (FIRST) (MI) **DOC#**_____

Application for New Life Recovery Program
River Of Life Rescue Mission

(A MINISTRY OF THE BOISE RESCUE MISSION MINISTRIES)

Please reply to Ray Carleton, CADC

575 S. 13TH Street Boise, ID 83702 Phone: 208-389-9840 ext.1512 Fax: 208-389-9773

rayc@boiserm.org for further correspondence and/or questions

PERSONAL INFORMATION

Please fill out neatly and completely.

TODAY'S DATE: _____

CURRENT MAILING ADDRESS: _____

_____

_____**PHONE #**_____

Mr._____ SS#_____
(LAST) (FIRST) (MI) DOC#_____

Other Names (Alias's) _____

DOB ___/___/_____Age ___ Place of Birth _____ Height_____ Weight _____

Marital Status_____ Driver's License #_____ State____ Expires___/___/ _____

Last known address _____How long did you stay there? _____

Currently staying? _____

How long have you been homeless? _____

Relative Nearest to You_____ Phone # ( ) _____

Are you a registered sex offender? ___Yes ___No

Are you a Vet? ___Yes ___No How long did you Serve? _____ Branch of Service _____

Church Affiliation

Church Attending _____

Address _____

Pastor's Name _____ Phone # ( )_____

Have you committed your life to Christ? ___Yes ___No When? _____ Where? _____

In your own words, describe what happened and how you felt _____

_____

_____

_____

Family information

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Name of Person involved with _____ _____

Their address: _____Phone #_____

Describe the relationship: _____

Are you expecting to become a new parent?_____ Due Date ___/___/_____

Children:

From any sexual relationships you have had in the past; how many children do you have? _____

Have any resulted in miscarriages? _____ How Many?_____

Have any led to abortions? _____ How Many?_____

Do you have you have custody or visitation of them?_____

Children:

1. **Name**_____DOB _____AGE _____M/F___

Address_____Last lived with you _____

Phone _____Mother or current custodial care person's name _____

Social worker_____Child entering residential program; ___ yes ___ no

2. **Name**_____DOB _____AGE _____M/F___

Address_____Last lived with you _____

Phone _____Mother or current custodial care person's name _____

Social worker_____Child entering residential program; ___ yes ___ no

3. **Name**_____DOB _____AGE _____M/F___

Address_____Last lived with you _____

Phone _____Mother or current custodial care person's name _____

Social worker_____Child entering residential program; ___ yes ___ no

4. **Name**_____DOB _____AGE _____M/F___

Address_____Last lived with you _____

Phone _____Mother or current custodial care person's name _____

Social worker_____Child entering residential program; ___ yes ___ no

Family of Origin

Mother _____Maiden Name _____

Address _____Phone: _____

Any addiction history, Relationship? _____

Father _____

Address _____Phone: _____

Any addiction history, Relationship? _____

Siblings;

Name _____M/F___Age _____Phone_____

Address_____

Any addiction history, Relationship? _____

Name_____M/F___ Age _____Phone_____

Address_____

Any addiction history, Relationship? _____

Name_____M/F___ Age _____Phone_____

Address_____

Any addiction history, Relationship? _____

Alcohol History

Describe your drinking pattern in the past: ☐ Daily ☐ Occasionally ☐ Binges

Explain: _____

_____

_____

_____

_____

_____

What was your longest period of sobriety in the past year? _____

What is the longest period you have been abstinent? _____

At what age did you take your first drink?_____

How long has drinking been a problem for you?_____

Drug History

Describe your pattern of drug use in the past 30 days: ☐ Daily ☐ Occasionally ☐ Binges

Explain: _____

_____

_____

How long has using drugs been a problem for you? _____

Have you used any of the following drugs? List date of last use:

Cocaine/Crack _____

Marijuana_____

Heroine/Opiates_____

PCP/Angel Dust_____

Crystal Meth _____

Alcohol _____

Prescriptions (yours, others) _____

Huffing (What) _____

Nicotine _____

Caffeine _____Other_____

Have you ever suffered severe withdrawal from any of these drugs? _____

Have you ever shared needles? _____

Do you have any specific concerns that you would like to discuss confidentially? _____

_____

Do you use tobacco/ nicotine products? ___Yes ___No If yes, what? _____

If you are currently incarcerated, did you smoke or chew before incarceration? ___Yes ___No

This is a non-tobacco use program. Are you ok with giving up tobacco products? ___Yes ___No

Shelter/Program History

Previous Programs or Shelters (Starting with most recent)

Program #1 Name _____Type _____

Location _____

Length of Stay _____Dates__/__/____ - __/__/_____

Did you graduate from the program? ___Yes ___No

Program #2 Name _____Type _____

Location _____

Length of Stay _____Dates__/__/____ - __/__/_____

Did you graduate from the program? ___Yes ___No

Have you ever been asked to leave? ___Yes ___No - If yes, why?_____

_____

_____

AA ___NA __ Name of Sponsor & Phone # _____

Meetings per week _____ What do you think is missing?_____

Medical History

All the following information is requested in order to serve you better. The Information provided will be kept in the strictest confidence by Boise Rescue Mission personnel.

Name: _____Date: _____

Date of Birth: ___/___/_____

IMPORTANT! Do you have any allergies to any medications? _____

Do you have any other life threatening allergies? _____

Have you ever thought about, planned, or attempted suicide? Explain:_____

_____

When and where was last attempt? _____

What was your method? _____

Names of medications you are currently prescribed to take and name of Physician:

Medication	Date Prescribed	Physician	Status (Have/Out of)

Do you have any physical disabilities that limit your ability to do certain types of work? ___Yes ___No

If yes, please describe _____

What type of pensions or benefits do you receive? _____

Do you have any of the following? Confusion: _____Memory difficulty: ____Mood swings: ____Depression: ____

Obsessions: Thoughts or urges to use: _____Anxiety: _____Stress:_____Problems sleeping: _____

Do you have any mental health/psychiatric issues or diagnoses?

_____

_____

_____

Do you have a Learning Disability or diagnosis? _____

PAST MEDICAL PROBLEMS
D0 YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
(Please circle if your answer is affirmative.)

1. Heart Disease
2. Lung Disease
3. Kidney Disease
4. Hernia
5. Sexually Transmitted Diseases
   - ___Gonorrhea
   - ___Syphilis
   - ___Herpes
   - ___Genital Warts
   - ___Chlamydia
   - ___Trichomonas
   - ___Crabs/Scabies
   - ___Other
   - _____
   - _____
6. Diabetes
   - ___Insulin Dependent
7. Tuberculosis
8. High Blood Pressure
9. Urinary Tract Infections
10. Test for Hepatitis

    Date___/___/_____☐A Results; ☐Positive ☐Negative

    Date___/___/_____☐B Results; ☐Positive ☐Negative

    Date___/___/_____☐C Results; ☐Positive ☐Negative

11. Test for HIV; Date___/___/_____☐Positive ☐Negative
12. Test for AIDS; Date___/___/_____☐Positive ☐Negative

SIGN AND SYMPTOMS
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
(Please circle if your answer is affirmative.)

1. Headaches
2. Visual Problems
3. Hearing Difficulty
4. Sore Throat
5. Difficulty Swallowing
6. Heartburn
7. Nausea
8. Vomiting
9. Diarrhea
10. Constipation
11. Blood in your Stool
12. Abdominal Pain
13. Cough
14. Sputum Production
    - ___Red
    - ___Green
    - ___Yellow
15. Shortness of Breath
16. Wheezing
17. Difficulty Breathing
18. Fevers
19. Chills
20. Sweats
21. Weight Loss
22. Dizziness
23. Yellow Eyes/Skin

13. Ulcer Disease
14. Eye Diseases
15. Ear Diseases
16. Sinus Infections
17. Previous Surgeries
18. Psychiatric History
19. Spinal injuries
20. Seizures
21. Other_____

_____

24. Dark Urine
25. Painful Urination
26. Rash

* Please Note: Due to public health code regulations some ministry assignments may be restricted for compliance reasons.

Have you been hospitalized? ____Reasons_____

Have you had any major accidents?_____

Do you have any major life threatening illness/disease?_____

Do you wear glasses? _____

Do you have any of the following? Confusion: _____Memory difficulty: ____Mood swings: ____Depression: ____

Obsessions: thoughts or urges to use:_____Anxiety: _____Stress:_____Problems sleeping: _____

Food addictions? (Caffeine, Corn Starch, Sugar, other) _____

Eating disorders? (Bulimia, Anorexia, other) _____

Sexual Activity

Describe your sexual activity

☐ Virgin ☐ Monogamous ☐ Several Partners ☐ Numerous Partners

Frequency of activity

☐ several times daily ☐ several times a week ☐ once a week ☐ other

Have you had or is it your practice to have sex with partners you do not know? ___Yes ___No

Have you had or is it your practice to have sex with partners affected with an STD? ___Yes ___No

If yes what was the STD? 1. _____ 2._____ 3. _____

Please circle the following with whom you have had sex?

Women Men

Do you understand that our program teaches the biblical doctrine of no sex out of the marriage covenant (Marriage being defined as the union between a man and a woman?) ___Yes ___No

Do you understand that our program teaches the biblical doctrine that only a heterosexual lifestyle is an acceptable lifestyle to God? ___Yes ___No

Education

High School Graduate? ___Yes ___No ___ Completed GED ___Yes ___No ___ College # of years_____ Degree

High School	Address

Business/Trade/Technical School	Address

College/University	Address

Are you enrolled in school? ___Yes ___No If yes, school attending _____

Course of study _____ Hours per week in school _____

Is Higher Education a goal you would like to pursue? ___Yes ___No

Do you have any personal hobbies?_____

Employment

Please list your previous employers:

Employer	Address	Position	Dates

What job or vocation has been most satisfactory?_____

Criminal History

List all of your convictions	County	Date of Conviction	Date of Release

Are you a registered sex offender? ___Yes ___No

Where are you currently registered? _____

For which crime(s)? _____

Are you currently incarcerated? ___Yes ___No

Location ___SICI ___ISCI ___IMSI Other_____

Parole Eligibility Date___/___/_____ Full-Term Release Date___/___/_____ Next Hearing Date___/ ___/ _____

Requesting parole to: Idaho, District # ___ Washington___ Oregon___ Other _____

If you are incarcerated, we must have a contact person in order to process your application in a timely manner:

Institution Counselor's Name_____Phone # _____

Probation/Parole Officer's Name _____Phone # _____

Attorney's Name _____Phone # _____

Pre-Sentence Investigator's Name _____ Phone # _____

Briefly explain why you are currently incarcerated_____

_____

_____

_____

Classes currently attending:

Class:	Facilitator/Instructor:

Criminal History Continued

What do you feel is the most serious problem you have yet to overcome?

_____

_____

_____

How did you hear about the New Life program?_____

Do you understand what is expected of you and are you willing to cooperate? ___Yes ___No

Describe your Current financial obligations; _____

_____

_____

_____

_____

Testimony

Explain to us why you want to change your life and what made you decide to seek help with us. How do you think this program and a better relationship with God can help you? What are your expectations? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND HONESTLY

1. What is your religious preference? Catholic___ Protestant___ Muslim___ Judaism___ Other_____

2. What are your feelings about participating in a biblically based program for self-improvement?

3. Briefly describe your family background (brothers, sisters, parents – married/divorced, etc.) as well as your relationship with them.

4. Are you married? If so, what is your relationship with your wife?

5. If previously incarcerated what are your feelings about the crimes you were convicted of?

6. Describe why you would like to be a part of the program at Boise Rescue Mission and how you feel we could best help you.

RELEASE OF INFORMATION

Client Name _____
Last Name First Middle

_____
Maiden Name Previously Married Name Date of Birth

I hereby request and authorize:
Name _____
Address _____
City _____State_____Zip_____

To Release to: Boise Rescue Mission Ministries
575 South 13th Street
P.O. Box 1494
Boise, ID. 83701

A copy of the following reports from the clients files:
Medical Information
Vocational Rehabilitation information and verification of services received.
Health & Welfare program information and verification of services received.
Employment agency information and verification of services rendered by
_____
Social service agencies services rendered by _____
Other pertinent information _____
_____
Exchange of verbal information _____
_____

This information will be used for:
_____

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to ANY or ALL of the above.

My signature below authorizes release of all such information to and from River of Life Rescue Mission and Boise Rescue Mission Ministries.

_____
Signature of Client or Responsible Party

_____
Relationship to Client Date

_____
Witness

To the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

To the party receiving this information; This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State Law. Federal and/or State regulations prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.